- the number of any repeat significant findings, if any,
- the number of repeat deficiencies, if any, and
- the number of repeat repeat deficiencies, if any.

The memorandum will indicate specific response instructions concerning time requirements for responding to general comments, deficiencies, repeat deficiencies, and significant findings.

(2) **Program Reviewer Assurance Statement and Signature.** This is a statement the RIC signs and dates that he or she has reasonable assurance that:

(a) The review was conducted in accordance with generally accepted government auditing standards.

(b) The findings of noncompliance with policy or inadequate controls contained in the program review report are supported by evidence that is sufficient and reliable.

(c) Findings of noteworthy accomplishments are supported by sufficient and reliable evidence.

(d) Within the scope of the review, the program is operating in accordance with applicable law and policy; and property and resources are used efficiently and safeguarded adequately, except for the deficiencies noted in the report and in the list of advised items that are supported and documented in the working papers.

(e) The name, title, and duty station of the other members of the review team will be placed directly under the assurance statement.

(3) **Lack of Assurance.** If conditions found during the review indicate widespread lack of policy compliance or inadequate administrative controls, thus preventing the RIC from making the assurance statement, the RIC must state and explain this clearly in this section of the report. It must also be emphasized in the review authority's cover memorandum, and special follow-up measures will be outlined.

The RIC may also be prevented from making the assurance statement because the scope of the review was impaired, unlimited access was not granted, or some event caused

the review team to leave the review incomplete through no fault of the reviewers or individuals under review. This must be explained in this section and in the cover memorandum.

(4) **Background.** This is a brief statement of facts describing the review site, gender of population, operational review dates, staffing pattern, program description, personnel in charge, recent events, etc. This information will reflect the current information available during the review week.

(5) **General Comments.** This section is open-ended and can be used for different purposes. It is not intended to be used for long lists of recommendations or suggestions to correct less important deficiencies that are not related to a significant finding. Such recommendations should be handled by giving the department head a separate list of items needing attention. Some purposes of this section include:

(a) Discussion of the rating for the review.

(b) Discussion of any issues that may require a specific response.

(c) Discussion of any issues and questions needing further study and consideration on a broader-based scale, such as possible changes to Bureau policy or training courses.

(d) Observation of areas not directly related to the program or discipline being reviewed.

(e) Summary of specific issues the review authority wants covered in every program review or in certain reviews.

(f) Response to the CEO's request that a specific issue be examined.

(g) Discussion of any innovative practices that were observed during the review week.

(6) **Significant Findings.** This section describes any significant findings based on the evidence gathered. The reader must be able to determine how the various deficiencies relate to one another and what impact the deficiencies are having or will have on the program.

(a) **Findings Format.** Significant findings must be numbered and normally relate to a specific program review objective. They must follow this format:

1. **Heading.** Describes the program area or topic involved. It must be meaningful to the reader.

   Examples: "Tool Control," "Staff Training"

2. **Condition and Effect.** A brief one or two sentence opening labeled "Condition and Effect" that informs the reader what the basic condition is and what basic effect it is having on the operation (or probable effect it will have if not corrected).

   Example: "There is a lack of adequate controls in the operation of the mailroom, resulting in misplaced mail, slow delivery of mail, inappropriate access to the mailroom, and a potential for fraud and lack of confidentiality."

3. **Evidence Section.** This is the heart of the finding and is labeled "Evidence." It is a brief but persuasive presentation of the pertinent, important evidence. It will note the extent and significance of problems and will be measured against what should be the criteria.

   It must be concise but informative, giving the reader the facts supporting the finding in an organized manner. Any deviations from policy, regulation, or ACA standards that have a direct relationship to the problem may be listed in this section or in "Other Deficiencies."

4. **Cause.** This is the underlying reason that the condition exists. Common causes include lack of training, lack of resources, inattention or negligence, inadequate or unclear guidance/policy, poor physical plant, etc. In some cases, the reviewer may be unable to determine the cause, and further study may be required.

If the cause is related to staff shortages or other lack of resources, the reviewer will so state. Budget constraints do not mitigate against the identification of significant problems caused by the constraints. Previous efforts to obtain funding to correct the problems will also be mentioned, so responsibility for future action can be assigned.

The reviewer should keep in mind that the policy may be the problem. In other words, the criteria used may need correcting rather than the condition at the review site. Perhaps the policy isn't written clearly, is outdated, or its requirements aren't needed. If the reviewer believes this to be the problem or part of the problem, it must be stated. This information will also be considered during the management assessment process.

5. **Recommendations.** These are actions the RIC presents to the CEO to correct, or lessen the impact of the conditions noted in the significant finding. All significant findings will include realistic recommendations. Reviewers will take the time needed to present recommendations that are clear, cost-effective, and address the conditions and causes.

(b) **Further Study.** Every significant finding will have a corresponding recommendation; however, there may be situations when neither the cause nor the solution or recommendation is apparent. Then, the "recommendation" may be to study the problem further, perhaps at the regional or national level.

(c) **Workable Solutions.** Various solutions will be discussed with the department head, regional administrator, associate warden, and, when appropriate, the person reviewed to ensure the solution (or series of options) eventually presented to the CEO at the closeout and in the written program review report will be realistic.

(d) **Interim Solutions.** The reviewer will be alert to innovative procedures or ways to improve operations that can correct or at least partially correct the situation - even if the basic cause is lack of resources, staff, or space.

(e) **Deviations from Policy/Regulation.** Although recommendations that require compliance with policy, regulations, or ACA standards are generally non-negotiable, a simple statement of compliance with policy is not adequate. The reviewer will specify the measures required to fully correct or improve the condition stated in the finding.

(7) **Repeat Significant Finding.** A repeat significant finding is a finding listed on the current review that was also listed during a previous formal review. While a repeat significant finding occurs infrequently, it should be noted that it does not have to be a mirror image of the previous finding.

Different evidence may be used to indicate a component weakness that was found during the previous review. Repeat significant findings will be developed from the prior program reviews, not operational reviews.

(8) **Repeat Repeat Deficiencies.** A list of current deficiencies also listed as deficiencies during the last program review and prior program review(s). The CEO will be instructed, in the review authority's cover memorandum, to explain why corrective action was not taken or was not effective prior to the review and what specific controls will be implemented to ensure deficiencies do not recur.

(9) **Repeat Deficiencies.** A list of current deficiencies also listed as deficiencies during the last program review. The CEO will be instructed, in the review authority's cover memorandum, to explain why corrective action was not taken or was not effective prior to the review and what specific controls will be implemented to ensure deficiencies do not recur.

When several operations become a shared service, the deficiencies from each operation's prior review will be considered as potential repeat deficiencies. The shared service review will not be considered a first time review.

(10) **Commendations.** Programs, procedures, or management practices identified as innovative, which involve cost-effective use of existing resources and have potential applicability in other Bureau settings.

(11) **Other Deficiencies.** This section lists problems or weaknesses the reviewer noted. The reviewer will include a one or two sentence summary of the problem and, if applicable, a reference number of policy(ies), regulation(s), or ACA standard(s). Those deficiencies that need a separate, specific response from the review site will be noted as "response required." During discussions with the department head, the reviewer must ensure the department head has an understanding of what action is required to remedy the situation.

Deficiencies or need for improvement not considered significant enough to be included in the program review report will be conveyed to the department head and documented in the working papers. The RIC will ensure the department head initials the working papers to verify advisement.

The RIC may also prepare a separate document known as the "Advised List," listing issues not considered significant enough to warrant inclusion in any part of the program review report. This document will be distributed to the CEO, regional administrator, and department head; a copy will be placed in the official program review file with the working papers. Because the "Advised List" is not included in the program review report, no response is necessary.

7. **PROGRAM REVIEW FOLLOW-UP.** The follow-up phase begins immediately after the program review report is distributed and continues until the review authority closes the review officially.

a. **Responsibilities.** The responsibilities for program review follow-up are divided between the reviewer and the institution as follows:

(1) **Responsibilities of Reviewer.** It is the RIC's responsibility to keep the review authority informed as to the adequacy of the response and corrective actions taken by the institution. It is also the RIC's responsibility to ensure timeliness of the request for closure is within established time frames, the review closure is warranted, and that a monitoring system is

in place to follow up on "post-closure" long-term actions through the strategic planning process when applicable.

(2) **Responsibilities of Review Site.** It is the responsibility of the review site's CEO to respond to the review report in a timely manner, take appropriate actions to correct deficiencies and improve operations, and ensure adequate administrative controls and monitoring systems are in place to prevent the deficiencies from recurring. When applicable, long-term corrective action will be monitored through the strategic planning process. As a reminder, any corrective actions taken that affect working conditions of bargaining unit employees will be handled in accordance with the Master Agreement.

(3) **Responsibilities of Regional Program Administrator.** Each discipline's regional program administrator will monitor the implementation of corrective actions and placement of internal controls the CEO outlined in response to review findings. Furthermore, the regional administrator will work closely with the institution to develop strategic initiatives to address issues noted during the program review and the operational review.

Through the effective use of management indicators for vital functions and the strategic planning documents, the regional administrator should be able to assess the level of program performance from a distance and advise the department head on potential corrective action.

b. **Response to Program Review Report.** The CEO must respond to the review authority via BOPNet GroupWise (with electronic copies to the appropriate assistant/regional director) no later than 30 calendar days after receiving the report. The review authority must approve any exceptions (see the Management Control and Program Review TRM for a response sample). The CEO's response must address:

(1) **Repeat Significant Findings.** The CEO will provide a separate response to the Director through the regional director. The CEO must describe the measures and internal controls to be implemented to ensure the problem will not recur, as well as explain why the problem was not corrected from the prior review.

(2) **Repeat and Repeat Repeat Deficiencies. The CEO must describe the measures and internal controls that will be implemented to ensure the problem will not recur, as well as explain why the problem was not corrected from the prior review.**

(3) **Other Deficiencies.** The CEO must certify that all deficiencies listed in the program review report (including those involving significant findings) have been corrected. This can be a blanket statement with exceptions noted. If a specific response for a deficiency is requested in the program review report, the CEO must provide a separate response for the deficiency.

Normally, deficiencies from policy or regulation are not negotiable. They must be corrected timely, unless budget constraints or other justifiable constraints preclude compliance.

Any constraints must be explained and a realistic time frame for correction must be specified using the strategic planning process. If corrective action requires longer than 30 calendar days, a strategic action plan will be developed for each area as part of the closure process. These action plans will be evaluated as part of the request for closure from the CEO.

If the program review included multiple disciplines, such as Human Resource (Employee Development, Personnel, and Affirmative Action), the response should include all disciplines and not be separated into different responses that are submitted at different times.

If there are constraints in resolving deficiencies involving a significant finding, the response to that finding will be referenced and the constraints discussed therein.

(4) **Significant Findings and Recommendations.** The CEO is required to respond to recommendations relating to significant findings cited by the RIC, declaring agreement or disagreement.

(a) **Agreement.** If the CEO is in agreement, the steps taken or planned to comply will be listed, with a time frame for resolution specified.

(b) **Disagreement.** Through discussions during the program review between the RIC, the department head, associate warden, and, when appropriate, the person reviewed, potential for disagreement with findings or recommendations should be reduced. However, the CEO may wish to present in the review response justification why the recommended action cannot or should not be taken and alternative methods of correcting the problem or improving the program. The review authority will make the final decision to accept or reject the CEO's response.

(c) **Non-Policy Based Criteria.** A Bureau reviewer is an official representative of, and reports directly to, the review authority (PRD SDAD). If the reviewer has determined that, in his or her professional judgment, an action should be taken to correct a problem (e.g., implement internal controls) or improve a situation (even if the criteria against which the condition was measured are not contained in policy or regulation), and if the review authority agrees with this judgment, it is incumbent upon the CEO to take such action or present adequate justification as stated above under "Disagreement."

(5) **General Comments.** The CEO will also review other sections of the program review report (Cover Memorandum, Background, General Comments, etc.) to determine if issues have been raised that require a response. The CEO must respond to issues identified in the General Comments section of the report if a required response is indicated. The CEO has the option to disagree with the General Comments item, but a response is still required.

(6) **Review of Response.** The RIC will review the CEO's response to ensure it is complete and all deficiencies have been corrected or the action plan contains an acceptable time frame for corrections. If there is a disagreement between the reviewer and the CEO regarding any finding or recommendation, the matter will be presented to the review authority for a decision.

(a) **Notification.** The review authority will notify the CEO in writing of the acceptance or rejection of the response within 20 calendar days of receipt.

(b) **Follow-up Reporting.** Included in the review authority's response may be the requirement for any follow-up reporting measures (progress reports, plans of action) to be taken on the CEO's part. The requirement for these reports is on a case-by-case basis and may be used when the time frame for corrective action is over a long period or the implementation of adequate internal controls is a concern.

(7) **Closure of the Program Review.** Before the review authority can close a program review, several actions are required by the RIC and institution to provide the review authority with the necessary assurance.

(a) **Follow-up Review by Institution.** Prior to seeking closure of the program review, the CEO will ensure a follow-up review is conducted to determine whether adequate internal controls are in place to prevent the problem(s) from recurring.

(b) **Responsibility.** The appropriate associate warden or management official is responsible for the follow-up review being conducted.

(c) **Review Team.** The associate warden may conduct the review personally or may head a review team. A local option might include appointing other institution department heads as members of the review team to provide cross-discipline training. Another local option is to include the department head or staff of the department in question on the review team. Consideration should be given to the workload of the staff assigned to the team.

(d) **Time Frame.** The follow-up review should be conducted 120 - 150 calendar days after the last day of the program review. This allows for sufficient time for internal controls, that have been put in place as a result of the review, to begin working.

(e) **Method.** Each deficiency mentioned in the review report is to be examined to determine not only whether the deficiency has been corrected, but also whether adequate, cost-effective controls have been instituted to lessen the likelihood of recurrence. Such controls might include: an additional level of review, more frequent inspections, cross-checking systems, new written procedures, improved training, etc.

Any deficiency(ies) noted in the program review report that requires a separate, specific response from the review site must be examined.

In regards to a significant finding, the review team is to ensure the "condition" as well as the "cause" have been addressed and staff have implemented the reviewer's "recommendations."

(f) **Report.** The associate warden will prepare a report of the review team's findings within 14 calendar days of the follow-up review date and send it via BOPNet GroupWise to the review authority (with electronic copies to the assistant director for the discipline reviewed and the regional director) under cover memorandum from the CEO.

The report will address all deficiencies noted in the program review report that require a separate, specific response, all repeat deficiencies, all repeat repeat deficiencies, and all significant findings, to include whether the controls put in place to correct weaknesses or deficiencies have been effective (see the Management Control and Program Review TRM for a Follow-up Review Report sample). This memorandum can also be used to request closure of the program review (see "Request for Closure").

(g) **Certification.** The associate warden's certification of correction of the deficiencies and adequacy of controls will be included in or attached to the report.

(8) **Request for Closure.** When the CEO is confident that all necessary actions have been taken, he or she must submit electronically a request for closure of the program review (see the Management Control and Program Review TRM for Request for Closure sample).

(a) **Time Frame.** Normally, closure of program reviews will be within 180 calendar days after the last day of the program review. If the CEO is unable to request the review's closure within this time frame due to extraordinary circumstances, he or she may submit via BOPNet GroupWise a request for an extension from the review authority.

(b) **Requirements.** In the cover memorandum to the review authority, the CEO will certify that he or she has reasonable assurance that all deficiencies noted in the program review report have been corrected and needed improvements have been made (except where noted elsewhere in the response), and that adequate controls are in place to prevent recurrence. An electronic copy of the follow-up review report will accompany the request for closure.

(9) **Assurance/Closure.** When the review authority has obtained reasonable assurance the deficiencies have been corrected, the review authority will notify the CEO electronically the review is considered closed. Electronic copies of this notification will be sent to the appropriate assistant and regional directors and regional/Central Office administrator(s).

(a) **Exceptions.** There are instances when limited resources or other restrictions preclude achieving full compliance within 180 calendar days. The review authority will consider such situations on a case-by-case basis. If the program is rated 'at risk,' the CEO will determine when he or she is prepared to request closure. At that point, the CEO is to request closure through the regional director.

If the regional director concurs, the request is forwarded to the Director with a copy to the PRD SDAD. A full program review is then scheduled. If the situation is resolved fully or if the stated strategic plan to correct the problem over the long term is realistic and fully responsive to

the review finding, the review can be closed. The review authority and regional administrator, however, must continue to monitor the progress against the established action plan through the strategic planning reporting system.

(b) **Assurance Methods.** These include, but are not limited to, the written assurance by the CEO that the follow-up review confirmed correction of all deficiencies, an on-site visit by the reviewer, a member of the review team, or a knowledgeable third party from the regional office or another facility, or a follow-up review directed by the review authority.

CHAPTER 3 - CONDUCTING AN OPERATIONAL REVIEW

1. **OVERVIEW.** The operational review is a local evaluation process that enables staff to closely evaluate the strengths and weaknesses of a program and take corrective action.

The operational review is conducted under the authority of the CEO of each installation or organizational component. At the institution level, the review authority is the Warden. At the region or division level, the regional director or the assistant director is designated as the review authority. The community corrections regional administrator (CCRA) is the review authority for operational reviews of Community Corrections offices. For operational reviews of Transitional Services and CCRAs, the regional director is the review authority.

As part of the Bureau's management control program, each program at all organizational levels should conduct an operational review between 10 - 14 months from the week of the previous program review (including those programs receiving a deficient rating). An additional operational review should be conducted 22 - 26 months from the week of the previous program review for those programs that receive good or superior ratings.

Regional program areas that receive superior or good ratings should also conduct two additional operational reviews at 34 to 38 and 46 to 50 months. An operational review is not required for those programs that receive an 'at risk' rating. Newly activated institutions will conduct operational reviews within the first 12 months after formal activation (i.e., issuance of the Operations Memorandum (OM) indicating the site's activation).

Apart from these requirements, an operational review may be conducted at any time to determine program effectiveness.

By using this process effectively, weaknesses can be identified and corrected quickly through strategic planning. Action plans can be developed to ensure correction over time and the strengthening of the program. Further, the operational review process enables program managers to establish strong internal controls to ensure corrective action continues to be effective.

2. **CONDUCTING AN OPERATIONAL REVIEW.** An operational review includes the five phases of the program review process (preparation, examination, evaluation, reporting, and follow-up) discussed earlier in Chapter 2.

a. **Responsibility.** Responsibility for ensuring the operational review is conducted in accordance with policy rests with the appropriate associate warden, deputy regional director, or deputy assistant director. The CEO is the review authority for all operational reviews.

b. **Members of Review Team.** The review team RIC and its membership are at the CEO's discretion. The RIC should demonstrate good organizational and communication skills, and a sound working knowledge of the operational review process. There is no requirement that the RIC be the department head of the program being reviewed, the review team can be made up of staff from any department. Consideration should be given to the workload of the staff assigned to the team.

It is essential that some team members be subject matter experts to ensure a comprehensive review is conducted and informed decisions are made regarding the review findings. It is the RIC's responsibility to ensure the operational review is conducted thoroughly and impartially and the review authority is advised of all findings.

c. **Preparation.** The review team will review the national PRGs and adjust them as necessary based on concerns and high-risk areas of the program as perceived by institution staff.

Staff from related departments will be included in a meeting(s) to enable the review team to take a "big picture" approach to the review - that is, looking at areas outside their own department that may affect, and be affected by, the program being reviewed. Through this process, a comprehensive review of institution operations can be made and improve the effectiveness of the institution programs. Coordination for this interdepartmental meeting will be the responsibility of the associate warden, deputy regional director, or deputy assistant director.

A brief memo announcing the upcoming operational review will be prepared and forwarded to the CEO (see the Management Control and Program Review TRM for samples). For Community Corrections operational reviews, the memo announcing the upcoming operational review will be prepared and forwarded to the CCRA.

d. **Examination and Evaluation of Evidence.** In accordance with the standards of evidence described in Chapter 2, the operational review team is to conduct the review thoroughly and impartially. The RIC must examine the materiality of the evidence and the existence of deficiencies, significant findings and repeat deficiencies or findings will be determined using the following criteria:

(1) **Deficiencies.** Generally reflect a deviation from policy, a weakness in internal controls, or noncompliance with an ACA standard.

(2) **Significant Findings.** Findings are generally composed of a series of related deficiencies that, taken together, constitute a failure of the program component. A significant finding can also be caused by a single event that results in program failure.

(3) **Repeat Findings/Deficiencies.** A repeat is the result of the failure of internal controls that were developed to correct a noted deficiency. In determining if a repeat exists, the evidence does not have to be a mirror image of the prior evidence. It is only necessary that the same condition exists. Repeat deficiencies/findings can be written based on prior program or operational reviews.

e. **Report.** The associate warden, deputy regional director, or deputy assistant director will submit the complete results of this review to the CEO, who acts as review authority, with a copy to the regional director (institution review) and the PRD SDAD, within 30 calendar days after the review is completed (see the Management Control and Program Review TRM for an Operational Review Report sample). For Community Corrections reviews, the RIC is to submit complete results to the CCRA, who acts as the review authority, with a copy to the regional director.

f. **Certification.** The associate warden, deputy regional director, or deputy assistant director will certify that the operational review was comprehensive and conducted in accordance with policy. Also, the certification is to include that findings and conclusions are supported by evidence contained in the working papers that are to be retained for review by the program review team during the next program review.

g. **Working Papers.** The department head or administrator of the program reviewed must retain the working papers for subsequent operational reviews as well as the report in an appropriately labeled file until the next scheduled program review has been conducted and a final report issued. During the next program review, the reviewers are to examine working papers from the operational review to determine that the review was comprehensive and that the adequacy of controls were assessed.

The effectiveness of corrective action will also be evaluated to serve as an indicator of the operational review program's overall effectiveness. Working papers and associated correspondence for Community Corrections operational reviews will be maintained in CCM offices where the review takes place.

h. **Closure of the Operational Review.** The review authority will direct that a follow-up review be conducted to measure the effectiveness of corrective action. The follow-up review will be conducted 120 - 150 calendar days after the last day of the operational review. It will be under the associate warden's supervision (institution reviews) and focus on areas of concern and deficiencies.

After the follow-up review is completed and it is determined that all controls are effective, the review authority can close the operational review. If there were no deficiencies or major concerns expressed or identified in the operational review report, no follow-up review is required, and the operational review may be considered officially closed.

i. **Exemptions.** The PRD SDAD, may grant an exemption to the operational review process when justified by the CEO and respective regional director or the Central Office assistant director.

CHAPTER 4 - MANAGEMENT ASSESSMENT PROCESS

1. **OVERVIEW.** A management assessment is a systematic method of assessing the strengths and weaknesses of a particular program/activity. It provides the opportunity to assist program managers to identify systems of control needed to ensure performance and compliance with applicable policies, regulations, and ACA standards.

Program Review Guidelines (PRGs) are developed to measure performance in meeting the identified program objectives. An in-depth management assessment will be conducted every three years. These PRGs may be reviewed and changed prior to the full management assessment using the midstream procedures.

2. **PURPOSE.** The management assessment's purpose is to examine each component of a program in order to determine:

a. Degree of vulnerability of the program to fraud, waste, abuse, and mismanagement.

b. Potential for serious problems if policy and regulations are not followed, or systems of internal controls are not adequate.

c. Degree to which resources are being used efficiently to satisfy performance requirements.

d. Areas or processes where the reviewers should concentrate their limited time and resources.

3. **METHOD/COMPONENTS.** Management assessments are conducted in a conference setting **at the Central Office**, and time is set aside exclusively for the assessments. The major components of a management assessment are:

a. A review of past and current performance, using available management indicator data/analyses.

b. An assessment of the program's level of risk and need for improved systems of control by means of a structured review methodology (risk analysis).

c. A review and incorporation of all current mandatory and nonmandatory standards assigned to the discipline. Guideline steps supporting ACA standards cannot be modified and/or removed unless the standard itself has been revised/deleted from the ACA standards manual or the nonmandatory step risks out low.

4. **PARTICIPANTS.** Management assessment teams consist of a total of 10 participants including the:

- Central Office administrator(s),
- regional administrator(s),
- warden(s),
- associate warden(s),
- institution department head(s), and
- a PRD senior reviewer.

A PRD evaluation specialist will facilitate the management assessment, and events will be recorded by a staff member the discipline selects. Any deviations or changes in regard to location or team size must be submitted for approval by the PRD SDAD and assistant director over the discipline.

5. **PREPARATION.** Prior to the management assessment, meetings will be conducted with the Central Office discipline administrator(s) and PRD staff to discuss current guideline steps and changes in policy or procedures which may impact the assessment process. PRD will also solicit input from all CEOs on any issues or concerns with the current guidelines.

Information will be gathered and assembled for distribution to all participants. The information will include:

- mission statement of the program,
- current PRGs and vital functions,
- definitions and terminology,
- CEO responses,
- deficiency trends and analyses (e.g., Quarterly Summary Reports and review surveys),
- GAO/OIG information, and
- applicable ACA standards.

6. **CONDUCTING THE ASSESSMENT.** The assessment is performed by identifying and reviewing each major area of responsibility/activity of the program to determine:

a. Program objectives.

b. Inherent risks (worst-case scenarios without controls in place).

c. Procedures or systems of control and their adequacy (e.g., policy, regulations, and oversight).

d. Actual risk to the program's mission based on the controls in place to address the identified inherent risks.

e. Review procedures needed to measure program performance and compliance with policy, regulation, and ACA standards.

7. **ASSESSMENT RESULTS.** Results of the management assessment include the development of PRGs and may also result in the identification of strategic issues, systems of control, and necessary changes in policy. Guideline steps are required for all high-risk processes (as identified in the risk analysis) and are recommended for all medium-risk processes.

Guidelines should be written clearly, granting the reviewer the opportunity to observe a program activity, review pertinent documentation, and/or interview appropriate staff. Guidelines should not be written as survey questions, but will be direct and substantial, relating to exactly what the reviewer should do.

It is equally important to indicate the sample size of items to be reviewed. The sample size specified should be sufficient to determine compliance but should not be excessive and lengthen the review process.

To facilitate the use of guidelines for operational and program reviews, a policy citation or regulation with the appropriate chapter or section will be ascribed following each review step.

IRP requires that all applicable ACA standards for each discipline be addressed in the program review process. Therefore, applicable ACA standards will be included in formulating guidelines during the management assessment process and should be ascribed following the policy citation or regulation.

8. **FORMAT OF PRGs.** The format for each PRG is prescribed in this PS. Each document will include the following standard statements regarding vital functions and ACA standards:

- During the management assessment, vital functions for (name the discipline) were identified as follows: (list the vital functions and number them). The guideline steps that measure or evaluate each vital function are identified in the left margin with the notation: **(V-1)**, **(V-2)**, **(V-3)**, etc.

- The following ACA standards are referenced in the attached PRGs: (list the ACA standard numbers). Review guidelines that measure or evaluate compliance with ACA standards are identified with the appropriate ACA number following any policy citations. Mandatory ACA standards are identified by **bold** print.

9. **PRG ROUTING PROCEDURES.** The PRD facilitator is responsible for preparing and routing the draft PRGs developed during the management assessment. To ensure PRGs are submitted to the Office of National Policy Review for publication within 90 business days from the management assessment's completion, the following routing procedures/time frames have been established.

Within seven business days after the management assessment, the initial draft will be routed to the discipline for review and assurance of appropriate policy citations and applicable ACA standards for each guideline step.

The discipline will review, finalize (policy citations and applicable ACA standards), and return the draft to the PRD facilitator no later than 30 business days from receipt of the initial draft.

Within a period not to exceed 50 business days:

a. the final draft will be prepared and routed within PRD for review;

b. the final draft will be submitted for approval/signature of the PRD SDAD;

c. the PRD facilitator will meet with the discipline's program administrator(s) for review and approval of any modifications resulting from PRD's internal review; and

d. the discipline's program administrator will then submit the draft for the respective assistant director's approval/signature.

Upon receiving the approved draft (signed by the discipline's assistant director), the PRD facilitator will prepare and submit the approved draft to NPR for publication within three business days from receipt of the final document. Institutions will be notified prior to implementation of new guidelines.

10. **COMPONENTS OF GUIDELINES**

a. **Program Objectives.** Objectives should be clearly written and state the purpose of the program area/activity and the results or level of performance expected. For example, "to ensure all sentence computations are completed accurately to prevent untimely releases" addresses the level of performance expected (all/100 percent accuracy) and the expected results (prevent untimely releases). Vague objectives should not be used such as "to enhance, to improve."

b. **Background Statement.** Under each objective will be a brief background statement indicating why this is a program review objective. For example, it may be a "high risk" area based on the management assessment, a life safety or statutory requirement, or an area that has consistently been a problem, such as overcrowding.

c. **Program Review Steps.** Directly under each program review objective and its background statement are the program review steps. The steps describe the work that is required to meet the program review objective. The steps should outline:

- the work to be done during the review,
- the specific documents to be examined,
- sampling techniques and sizes to be used,
- span of time to be reviewed,
- processes to be observed,
- persons to be interviewed, and
- purpose for the program review step.

The program review steps must be clear enough that a person who is not an expert in the program area or who is not an experienced reviewer can, with supervision, understand the program/operational review work that is required. Each review step must also cite the appropriate supporting reference.

An appropriate example would be: (PS 5500.03, CH 7, Sec 701) and ACA standards: 3-4023, 3-ALDF-4D-17. This specific citation will reduce the amount of time spent looking through policy when citing deficiencies, and it will enable line staff to become more familiar with specific policy requirements when preparing for or conducting an operational review or a program review. Assessing the adequacy of the evidence collected and organizing the evidence into findings remains the RIC's responsibility.

The following is a sample format to be used in developing program review steps: **Look at** ...(a specific activity, program, or program component) **to determine** ...(specific objectives are being met or policy requirements complied with...). Two examples of guidelines follow that involve a reviewer observing a program first-hand, reviewing documentation, and interviewing staff:

- Observe an actual team meeting to determine whether staff are developing a financial responsibility plan at initial classification and program reviews.
  (PS 5500.03, CH 7, Sec 701)
  ACA: 3-4023, 3-ALDF-4D-17

- Examine five percent (not to exceed 25) of the central files of cases identified as participating in the Inmate Financial Responsibility Program (IFRP) and review Attachments A and B to determine whether they are completed and in the central file. (PS 5500.03, CH 8, Sec 7)

11. **MIDSTREAM REVISIONS.** Midstream revisions to guidelines may be made at any time due to changes in policy, Executive Staff decisions, memorandums issued by assistant directors, etc., that occur prior to the three-year cycle for full management assessments. Once national policy has been published, the relevant program review guidelines will be modified if applicable, to reflect policy changes that affect the guidelines. These changes will occur as soon as practicable, ordinarily will not exceed six months. A memorandum outlining the requested change(s), purpose for change(s), suggested revision(s), and contact person should be routed to the PRD SDAD and assistant director for that discipline.

12. **DOCUMENTATION.** It is the PRD facilitator's responsibility to ensure that necessary documentation of the assessment is maintained. The PRD facilitator must retain documentation in an appropriately labeled file until the next management assessment is completed (every three years).

CHAPTER 5 - CORRECTIONAL STANDARDS AND ACCREDITATION

1. **INITIAL ACCREDITATION.** Institutions will begin the initial accreditation process **within 12 months of activation** and request a **Standards Compliance Audit with ACA within 24 months of activation.** The Director can grant exceptions to this time table when requested by the regional director through the PRD SDAD.

An institution representative is required to attend the formal panel hearing before the CAC for initial accreditation. The Warden's presence at the initial accreditation panel hearing is strongly encouraged. Institutions are encouraged to send a representative to subsequent panel hearings for reaccreditation. The SMS will provide funding for the institution representative to attend the panel hearing for initial accreditation or reaccreditation.

At each institution the local union president will be afforded the opportunity to hold a seat on the ACA accreditation committee, in accordance with Art. 10 of the Master Agreement.

Fees for accreditation and reaccreditation are to be paid through the existing contract, which the Bureau accreditation manager manages, between the Bureau and ACA.

a. **Applicable Standards.** Currently, three sets of ACA standards apply to Bureau operations:

(1) **Standards for Adult Correctional Institutions 3rd Edition.** These standards apply to Administrative Maximum Institutions, Penitentiaries, Federal Correctional Institutions, Federal Correctional Complexes, Federal Medical Centers, and Federal Prison Camps.

(2) **Standards for Adult Local Detention Facilities 3rd Edition.** These standards apply to Metropolitan Correctional Centers, Metropolitan Detention Centers, Federal Detention Centers, Jails, and the Federal Transportation Center.

(3) **Standards for the Administration of Correctional Agencies.** These standards apply to the Central Office.

The Warden will provide a copy to the local union president, upon request, of the current ACA standards applicable to the particular institution. This includes any subsequent supplements published. The national executive board of the Council of Prison

Locals will be provided a copy of all current standards for all facilities, upon request.

b. **Accreditation Timetable.** The accreditation time table begins with the OM activating the institution. Once activated, the institution has 12 months to enter Correspondent Status with ACA and begin the accreditation process. Within 12 months of entering Correspondent Status, the institution must be prepared to invite the visiting committee to the institution for the on-site compliance audit.

Steps in the initial accreditation process include:

(1) Approximately 12 months after the institution's activation, the Bureau accreditation manager makes an on-site visit to explain the accreditation process to staff and meet with the accreditation committee. The purpose of this visit is to assist specifically in:

- the role of the committee,
- preparation of files, and
- what the institution can expect during the auditor's visit.

During this visit, the Bureau accreditation manager assesses the institution's readiness to pursue accreditation and forwards this assessment through the PRD SDAD to the regional director and the Warden.

(2) The Warden will request, through the regional director to the PRD SDAD, that the Bureau accreditation manager forward the Task Order initiating the accreditation to ACA.

(3) Upon the Task Order's issuance, the institution will interact with both the Bureau accreditation manager and the ACA regional manager on issues related to the accreditation process. Copies of all correspondence will be forwarded to both Central Office and regional office accreditation managers. Both the Bureau and regional accreditation managers provide assistance as required.

(4) Normally, the correspondence phase of the accreditation process requires up to six months. The institution should complete the self-evaluation six months after entering Correspondent Status. The institution enters Candidate Status after completing the self-evaluation.

Once the institution has entered Candidate Status, it requests an on-site visit by the Bureau accreditation manager to conduct the final in-house audit and tentatively schedule the visiting committee audit with ACA.

(5) Assuming the in-house audit's successful completion, the institution accreditation manager, in conjunction with the Bureau accreditation manager, will confirm the visiting committee audit with ACA.

(6) After the visiting committee audit, the Bureau accreditation manager provides assistance to develop appeals or plans of action for those standards found in noncompliance.

(7) An institution representative and the Bureau accreditation manager attend the accreditation hearing before the CAC to represent the institution. The regional accreditation manager is encouraged to attend this hearing.

(8) The institution representative will attend the awards ceremony to receive the institution's certificate.

(9) Retention or maintenance of ACA files beyond initial accreditation is not required. Reaccreditation is accomplished through the program review process.

c. Institutions not ready to pursue accreditation consistent with the above time line, must request a waiver from the Director through the regional director and the PRD SDAD. This waiver is to be submitted in the form of a memorandum and should state the reasons for the request to delay the initiation of the process. Generally, a request for a waiver must be initiated within 14 months of activation.

2. **REACCREDITATION (IRP)**

a. **Ongoing Monitoring of Compliance.** The continuing accreditation of Bureau institutions is accomplished through the Bureau's own program review process. Central Office program managers must ensure that PSs and PRGs reflect all standards applicable to the Bureau. PRGs will include all mandatory standards and nonmandatory standards provided to the discipline prior to the management assessment.

Consistent with this PS, program and/or operational reviews will be conducted in each program area annually. Accreditation managers must document these reviews and make them available to ACA auditors upon request. ACA auditors will place a special emphasis on program review findings which are linked to mandatory standards.

Accreditation managers should ensure that corrective actions and related documentation demonstrate ongoing compliance with associated mandatory standards. Central Office division accreditation managers will document any program and/or operational reviews conducted within their divisions. Institution accreditation managers are responsible for documenting program/operational reviews conducted locally.

b. **ACA On-site Monitoring.** Since the IRP relies on the program review/operational review process' integrity, ACA auditors will accompany program reviewers during routine program reviews to confirm the process' integrity and that all applicable standards are being addressed during operational and program reviews.

An ACA IRP on-site monitoring visit occurs once during an institution's three-year period of accreditation. The Bureau accreditation manager will provide ACA with a current schedule of program reviews, and ACA will determine which program reviews will include an ACA monitor.

Approximately 60 days prior to the review, the PRD SDAD will notify the CEO and regional director of the upcoming ACA audit.

At the conclusion of the review, the RIC forwards a copy of the final report to the Bureau accreditation manager, who then forwards a copy to ACA.

c. **Annual Certification.** Each accredited institution and the Central Office must provide an annual certification report to the ACA documenting the following:

(1) Progress on action plans to address standards found in noncompliance during the initial audit.

(2) Identification of those program reviews conducted since the last annual report or hearing and the ratings received.

(3) New litigation regarding conditions of confinement initiated since the last annual report or hearing and its current status.

(4) An update on any significant occurrences at the institution since the last report or hearing (e.g., escapes, serious assaults, executive staff moves, mission change, etc.).

This report is due on the initial accreditation or reaccreditation anniversary date. The anniversary date is determined by the month (January or August) an institution appeared before the CAC. It should be routed through the Bureau accreditation manager in ample time (30 calendar days) to ensure it will be received in the ACA office prior to that date.

3. **MONITORING VISITS.** When an institution is required to receive an ACA monitoring visit, ACA will fund the visit's cost. PRD can fund any related travel on the Bureau accreditation manager's part only at the PRD SDAD's discretion.

4. **PARTICIPATION IN ACA-SPONSORED ACTIVITIES.** Bureau staff participation in ACA activities and conferences is encouraged and valued. To ensure that participation is equitable, potential participants in national activities, who will be participating at government expense, must complete the Bureau's Personnel Participation in ACA Activity form and forward it to the Bureau accreditation manager at least 30 calendar days prior to the scheduled event. Completing Attachment A is not required for participation in local events, such as meetings of ACA affiliates or ACA sponsored training.

5. **PROPOSED ACA STANDARDS.** Individuals wishing to submit new or revised standards for consideration by the Standards Committee must submit the proposed change(s) or addition(s) on the appropriate ACA form to the Bureau accreditation manager at least 60 days prior to the date the revision is due to ACA. The Bureau accreditation manager will ensure that the Bureau addresses all issues consistently and considers agency wide implications.

All proposed change(s) or addition(s) must be approved/submitted by the PRD SDAD to ACA.

BUREAU OF PRISONS PERSONNEL PARTICIPATION IN AMERICAN CORRECTIONAL ASSOCIATION ACTIVITY

NAME_____

TITLE_____

PRESENT DUTY STATION_____

_____

_____

TELEPHONE NUMBER_____

EVENT, CONFERENCE, ETC._____

_____

LOCATION_____

LIST ELECTED OR APPOINTED OFFICES HELD IN ACA OR AFFILIATED ORGANIZATIONS_____

_____

ARE YOU PRESENTING AT A WORKSHOP, TRAINING EVENT, OR OTHER FUNCTION IN CONJUNCTION WITH YOUR ATTENDANCE AT THIS EVENT? YES__ NO__. IF YES, PLEASE IDENTIFY_____

_____

_____

_____

LIST ALL ACA ACTIVITIES YOU HAVE PARTICIPATED IN DURING THE LAST 12 MONTHS_____

_____

CHAPTER 6 - LIAISON WITH EXTERNAL AUDIT AUTHORITIES

1. **EXTERNAL AUDIT AUTHORITY.** Any designated official from a government agency outside the Bureau organization authorized to conduct audits of a program, operation, practice, or procedure of a Bureau component. Examples are:

- the General Accounting Office,
- the Office of the Inspector General, Department of Justice,
- the General Services Administration, and
- the Office of Personnel Management.

This does not include interactions with the Office of Enforcement Operations. Such activities are coordinated through the Correctional Programs Division.

2. **NOTIFICATION OF AN IMPENDING AUDIT**

a. **General Procedures.** Official notification of an impending audit is directed to the Director with a copy to the PRD SDAD. Upon receipt in PRD, the affected component(s) will be determined by the PRD SDAD, the PRD planning and analysis administrator, and the PAS liaison.

Once the determination is made, PAS notifies the affected component(s). The PAS liaison schedules and arranges an entrance conference at a time and place agreeable to all parties. Ordinarily, the entrance conference is held at the Central Office (PRD conference room), and its purpose is to identify the audit's scope and parameters. When external auditing authorities visit institutions, the local union president will be notified by the institution, when at liberty to do so, and which may involve questioning bargaining unit staff.

After the entrance conference, the PAS liaison is to brief the PRD SDAD and, if appropriate, complete a written summary report of the meeting for the PRD SDAD.

On occasion, the PRD SDAD may direct the PAS liaison to schedule a meeting of Bureau staff prior to the entrance conference to ensure staff coordination, address concerns, and/or identify Bureau resource staff.

b. **Direct Contact with a Component.** If an external audit authority contacts a component directly, via telephone or mail, the component must notify the PAS no later than the close of business that day. Details outlining the review's scope and

specifics, along with any written notification, are to be forwarded to the PAS liaison immediately.

c. **Unannounced Arrivals.** Ordinarily, the Bureau receives prior notification of an external audit authority's intent to review or inspect a particular site, but on rare occasions auditors may arrive unannounced. Should this occur, the CEO must request an entrance conference and contact the regional director and PRD SDAD for further guidance.

3. **AUDIT CONTACT.** Staff should exercise care in responding to auditor inquiries. Staff should be directed to respond only to questions they are qualified to answer. They should not answer if they are tentative or uncertain of the answer.

If Bureau staff refer the auditor to another staff person better qualified to respond to the question, the PAS liaison must be advised of the referral. It is important that the PAS liaison keep track of the source(s) of auditors' information in case differences arise. Also, the component must forward all written responses (via E-mail if short time frames are involved) to PAS to ensure appropriate quality assurance review and timely submission to the audit authority.

In addition, the PAS liaison must keep both the national and local impact of the audit in sharp focus. External auditors may uncover issues which require immediate corrective action or timely policy modifications. Likewise, issues which may generate unusual public concern or be of particular interest to the media can surface during an audit.

In such situations, the component's CEO must inform the regional director/assistant director and the PRD SDAD immediately. Also, the Office of Public Affairs must be contacted when media interests are likely.

4. **EXIT CONFERENCE.** Upon completing the actual auditing process, the external audit authority notifies the PAS. The PAS liaison is to schedule an exit conference with the Bureau component(s) and the external audit authority to provide opportunities for:

- Bureau staff to learn about and clarify tentative findings;
- Bureau staff and auditors to share ideas relative to tentative findings; and
- Bureau staff to take immediate corrective measures if warranted.

At the completion of the exit conference, the PAS liaison will brief the PRD SDAD and, if appropriate, complete a written summary report of the meeting for the PRD SDAD.

5. **RESPONSE REPORTS TO "DRAFT" AND "FINAL" AUDIT REPORTS.** If either a draft or final audit report is forwarded directly to the organizational component rather than the PAS, the component must forward the original copy to the PRD SDAD immediately for coordination and action.

Ordinarily, an external audit authority will only accept comments for up to 30 calendar days prior to publishing its final report and findings. Only the PRD SDAD may make a request for an extension on the Bureau's behalf.

6. **RESPONSE REQUIREMENTS.** Full cooperation with external audit authorities is required and expected. Any questions concerning the disclosure of specific documents or information should be referred to the PAS.

a. The PRD SDAD assigns initial responses to audit reports to the component(s) being reviewed.

b. The PAS is responsible for coordinating and submitting all Bureau responses for the proper signature.

c. Each Bureau response will express appreciation for the external audit authority's report and state the Bureau's position on the audit findings, including any planned actions. If the Bureau concurs with the findings and the proposed corrective action(s) are appropriate, the response will concur and address all infractions, deficiencies, and/or violations the audit authority cited.

d. The time frames for taking corrective action and the implementation of controls to prevent a problem's recurrence are to be described. Any delay in corrective action or the implementation of controls must be explained fully in the response.

If the Bureau suggests an alternate solution to the proposed corrective action(s), all relevant details, as stated above, are to be included in the response.

e. If the Bureau disagrees with an audit finding and/or recommendation, the response will include the rationale for the Bureau's position.

DEFINITIONS OF TERMS USED IN PROGRAM STATEMENT

ACA Regional Manager - The ACA staff member assigned to have oversight for BOP accreditation activities. He/she also functions as the primary contact person for BOP accreditation managers.

Actual Risk - The risk of a step demonstrates the negative impact the discipline will experience if the step is not in place. The actual risk is assessed during the risk-out portion of the management assessment process and is determined and rated (H, M, L) based on the adequacy of controls in place to address the worst case scenarios (inherent risk).

Advised Item - A weakness in a program/operation which indicates a problem may be developing but does not totally meet the standards of evidence for it to be a deficiency. While not included in the program review report, an advised item should be brought into full compliance during the follow-up review phase.

Assurance Statement - A certification that the program/operation/agency is operating effectively, efficiently, and in compliance with applicable regulations; and that existing systems of internal control adequately protect the agency's resources against fraud, waste, abuse, and mismanagement. The assurance statement must also identify any systemwide control weaknesses and actions taken or planned to correct the weaknesses in an appropriate and timely manner.

Conclusions - Interpretations of the evidence stated in relationship to the objectives of the review.

Deficiency - Problems or weaknesses noted by the reviewer which are in need of correction. In its broadest sense, a deficiency includes any condition needing improvement. A deficiency can include: noncompliance from policy/regulation; lack of adequate internal controls; poor or unprofessional practice; inefficient practice; ineffective results; poor quality, etc. A finding is usually based on several related deficiencies.

General Accounting Office (GAO) - The auditing arm of the Legislative Branch of the Federal Government given responsibility for monitoring the Executive Branch's implementation of Congressional requirements. The GAO also sets minimum standards to be met in implementing Congressional mandates (e.g., internal control standards). The GAO is headed by the Comptroller General of the United States; however, its monitoring/auditing function encompasses programs as well as financial areas.

Impairments - Impediments to conducting a program review in accordance with standards, specifically GAO Standards relating to independence. These impediments can restrict the program review or interfere with a reviewer's ability to form independent and objective opinions and conclusions. The impairment can be external, organizational, or personal.

- **External Impairments** - includes interference which limits or modifies the scope of a program review, restricts funds or other resources dedicated to the review organization, interferes with the assignment of personnel, overrules or influences the reviewer's judgment as to the appropriate content of a report or selection of what is to be examined, and jeopardizes the reviewer's continued employment with the agency or career advancement within the agency for reasons other than level of competence.

- **Organizational Impairments** - Review organizations should report results of the reviews and be accountable to the head of the agencies; reviewers should be removed from political pressures.

- **Personal Impairments** - include official, professional, personal, or financial relationships that might cause the reviewers to limit the extent of the inquiry, to limit disclosure, or to weaken findings in any way; preconceived ideas toward individuals or program objectives that could bias the review; previous involvement in a decision-making or management capacity that would affect current operations of the entity or program; biases that result from employment in, or loyalty to, a particular group or organization; and subsequent performance of a review by the same individual who, for example, had previously approved actions now under review or who maintained the official records now under review.

Inherent Risks - Worst-case scenarios that could prevent the accomplishment of the identified mission/objective.

Intensive Reaccreditation Process (IRP) - IRP combines the accreditation of Bureau institutions with the program review process to establish internal and external review of Bureau operations and programs.

Materiality - The significance of an item of information, given the circumstances, that allows a decision to be made.

Office of Management and Budget (OMB) - A function within the Executive Office of the President with responsibility for

coordination of all management and budget activities of the Executive Branch of the Federal Government. OMB issues circulars which give guidance to other departments and agencies as to how Congressional acts are to be implemented and GAO Standards complied with (e.g., A-123 for internal controls, A-127 for accounting systems, A-130 for ADP systems, A-76 for contracting out activities, etc.).

Oversight Authority - The Bureau review function which is reserved for the Director, Bureau of Prisons, and is delegated to the PRD SDAD. Oversight includes the determination of whether reviews are conducted in accordance with the provisions of this program statement and government auditing standards.

Performance Indicators - Process of increment of measure used to define progress toward an objective and is ideally expressed numerically. Indicators can be measured as a percentage from an established baseline or raw number. It is important to define clearly what should be measured within established time lines (performance targets) and should indicate progress as well as accomplishment of program objectives. These are tools used by managers to determine if program objectives (components) are being accomplished.

Program - A major activity or functional area of the Bureau, such as staffing, dental care, prisoner transportation, staff training. Several similar programs may be grouped to form a branch (in the Central Office) or a department (in the institution).

Program Review - Work done in reviewing compliance with laws, regulations and policy, adequacy of controls, efficiency of operations, and effectiveness in achieving program results - also referred to as a review, test, inspection and includes exploring and developing all pertinent and significant information necessary to properly consider, support, and present findings, conclusions, and recommendations. Work can go beyond determining compliance with regulation and policy (expanded scope review).

Program Review Closure - The act of formally closing the file on a program review, requiring reasonable assurance on the review authority's part that any improvements and corrective actions recommended by the reviewers have been taken.

Program Review Guidelines (PRGs) - The PRGs are the "road maps" developed by each program area to provide guidance to those staff who will be conducting program/operational reviews. Guidelines are developed via management assessments and provide the reviewer with the necessary information needed during the review to

accurately assess the performance/results of the program/activity.

Program Review Objectives - The major part of the guidelines document which outlines the focus (level of performance and results expected) of a particular program or activity during the review cycle.

Program Review Report - The medium through which an RIC communicates the results of the review.

Program Review Schedule - An annual schedule of individual reviews to be conducted during a fiscal year.

Program Review Steps - These are the instructions placed directly under each specific objective which outline, in detail, the specific documents to be examined, sampling techniques to be used, span of time to be reviewed, analytical work to be done, observations to be made, persons to be interviewed, interview questions to be asked, etc. These steps must be detailed enough that they will be understandable by assistant or trainee reviewers who are included on the team primarily for on-the-job training purposes.

Recommendations - The courses of action specified in the report to correct problem areas and to improve operations. The suggested course of action can be based on deviations from policy as well as other deficiencies or need for improvement.

Repeat Deficiency. A deficiency that was also listed as a deficiency during the last program review. A repeat deficiency is the result of the failure of internal controls that were developed to correct a noted deficiency. In determining if a repeat exists, the evidence does not have to be a mirror image of the prior evidence.

Reviewer - A qualified, trained employee who conducts program reviews on behalf of the PRD SDAD.

Reviewer Access - The assurance that the reviewers will have complete access to all records, property, operations, personnel, and inmates during a program review.

Review Authority - The Bureau official under whom the program review is carried out and to whom the RIC reports. This official must be a member of the Bureau's Executive Staff. In its broadest sense, the term review authority encompasses the official program review function of the Bureau delegated by the Director to assistant directors and regional directors.

Reviewer-In-Charge (RIC) - The reviewer that heads the program review team and reports directly to the review authority.

Risk Analysis - An intensive review of each component's vulnerability in carrying out its mission or stated goals. This is accomplished by balancing the probability of failure against controls in place, thus rating the actual risk or potential damage which could occur.

Significant Finding - A pattern of events or single event normally linked to a program review objective that indicates a deficiency in an organization or organizational element. A finding is usually based on several related deficiencies. This determination is based on the sound professional judgment of the RIC.

Special Review - The examination of a particular subject area in more depth than accorded in a routine review. It may involve several different disciplines or programs (suicide prevention controls; crisis intervention effectiveness; SENTRY training, coordination and accuracy; A&O program effectiveness; etc.). This is still considered to be a program review and provisions of this program statement apply. This type of review usually requires a special set of objectives.

Strategic Management Cycle - Is the dynamic process of improving programs through gathering, analyzing, and using information which leads to timely, effective, and continuous planning. The strategy is to merge the present with the future and knowledge with the commitment to improve.

Strategic Planning - The process the Bureau uses to identify local, regional, and national objectives that are critical to the accomplishment of the mission of the Bureau. This process also calls for the development of action plans and steps which identify required resources, set completion time limits, and specifies individuals responsible for completion of the task.

Technical Assistance - In its broadest sense, technical assistance is a component of any review and the purpose is to improve operations. However, in the Bureau, program experts often visit institutions or offices solely to provide expert guidance in a specific, complex program area or a team of experts may be called in to assist institution staff after program reviewers have discovered serious deficiencies.

For this Program Statement's purposes, technical assistance refers to a visit conducted for purposes other than a program review. Any summary reports of such a visit are prepared at the discretion of the regional or assistant director responsible for the visit.

Vital Functions - Those functions identified during the management assessment which must be performed to achieve at least a minimum level of successful performance. If controls are not in place to ensure current and future successful performance, the entire program is at risk and could result in failure to accomplish its mission. These areas are given special attention during reviews.

Working Papers - Documents that provide support for opinions, conclusions, and judgments. They aid in the conduct and review of the reviewer's work. Include the collection of schedules, papers, analyses, correspondence, and other material prepared or obtained prior to and during the program review. They are to be retained a period of 5 years from the date of the review.